EXHIBIT 1

REVIEW OF THE RESPONSE BY THE OKLAHOMA DEPARTMENT OF HUMAN SERVICES TO THE SUSPECTED ABUSE AND NEGLECT OF CHILDREN IN ITS CARE

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EXECUTIVE SUMMARY

At the request of attorneys for the plaintiffs in the federal class action litigation *D.G. v. Henry*, I have conducted a research review of the efforts of the Oklahoma Department of Human Services (OKDHS or agency) to protect children in its care and custody after receiving referrals in 2009 alleging that the children had been maltreated. The review evaluates four specific aspects of OKDHS's response:

1. The adequacy of Child Protective Services (CPS) investigations of allegations of abuse and/or neglect of OKDHS wards placed in foster or kinship care and the degree to which attendant decision-making is correct.

2. The adequacy of Office of Client Advocacy (OCA) investigations into allegations of abuse and/or neglect of OKDHS wards placed in residential treatment centers, group homes, shelters, and other congregate care settings and the degree to which attendant decision-making is correct.

3. The adequacy of Child Protective Services assessments of situations in which children in the care of OKDHS have allegedly been maltreated and the degree to which attendant decision-making is correct.

4. The degree to which decisions made at the OKDHS hotline to screen out (i.e., not investigate or assess) referrals alleging maltreatment, child abuse or neglect of children in OKDHS custody are correct.

In addition to this review, I have completed a review of the cases of nine children in OKDHS custody found by OKDHS to have died from child abuse or neglect since January 1, 2007. My conclusions from my review of these tragic deaths serve to illuminate the findings of the research review.

Investigations and screened out referrals were randomly selected for review from lists produced by OKDHS. The sample sizes are statistically significant – that is, they are large enough to give reasonable confidence that the findings of the review represent the findings that would result if the entire universe of all investigations and all screened out referrals concerning OKDHS wards that occurred in 2009 had been reviewed. In order to reliably extrapolate my findings to the entire universe of investigations and screen-outs, I used an accepted statistical calculation called a confidence interval. The confidence interval represents the range within which a particular result from my review applies with 95% certainty to the relevant universe. Thus, when I have stated my findings in terms of a range, I have determined that range to be correct with 95% certainty. Different findings have different confidence intervals because the findings take different subsets into account. Each of the confidence intervals used in conjunction with my findings are set forth in the text of this report.

All 2009 CPS assessments involving children in OKDHS care were reviewed.

III. STUDY METHODS

This cross-sectional case record review was designed to describe the characteristics of referrals alleging child maltreatment in out-of-home care in Oklahoma, to describe the response to these referrals, and to assess whether the decision-making involved in these investigations, assessments and screen outs reflects reasonable professional judgment and falls within minimal practice standards for child protective services.

A. Sampling Plan and Inclusion and Exclusion Criteria

OKDHS identified all cases in which, during calendar year 2009, children in its custody were the subjects of:

1. Child abuse/neglect referrals that were screened out at intake.

2. Child abuse/neglect referrals that received CPS investigation.

3. Child abuse/neglect referrals that received OCA investigation.

4. Child abuse/neglect referrals that received CPS assessment.

These referrals were unduplicated (i.e., referrals alleging the maltreatment of multiple children involved in a single incident or set of circumstances resulting in a single screen out decision, investigation or assessment were combined).

For three of these categories (screen outs, CPS investigations, and OCA investigations), a random sample was identified that was large enough to permit the review results to be generalized to the entire population in that category with a level of reasonable confidence. (Confidence intervals are identified for specific findings as they are relevant in the body of the review).

Random sampling is the most effective way of assuring that a sample is representative of the total population affected by screening decisions, investigations, and assessments completed during the study time period. On this basis, it can be assumed that the findings from this study represent the findings that would have resulted if the entire population of screen outs, CPS investigations and OCA investigations involving alleged victims in out-of-home care in Oklahoma during 2009 had been reviewed.

The samples for these three review categories are as follows:

Universe/Sample Size

Category	Unduplicated Universe (N)	Sample
CPS investigations		
referrals	343	84
OKDHS wards	645 (est.)	158
OCA investigations		
referrals	219	41
OKDHS wards	374 (est.)	70
Screen outs		
referrals	464	93
OKDHS wards	807 (est.)	162

Table III-1

The samples are large enough so that the results of the review can be applied to the universe of all CPS and OCA investigations, and all screened out referrals, concerning OKDHS wards occurring in 2009. For each key finding, a confidence interval can be calculated. The confidence interval is the range of the number of children, investigations, or screened out referrals affected by each key finding.

Because OKDHS identified only 17 CPS assessments in 2009 (involving 33 children in state custody), no sampling was performed and all 17 assessments were reviewed.

B. Data Collection and Coding Procedures

Following an analysis of Oklahoma state laws and of OKDHS policies and procedures, relevant data elements were identified and a coding system was developed for each category of intervention being studied. The data elements were structured into an Access database to capture case-level data, including:

- Background information (e.g., the initials and ages of alleged victims and the type of facility in which the alleged maltreatment allegedly occurred);
- Detailed information about the nature of reported allegations and the role of alleged perpetrators;
- For screen outs, information about the adequacy of the information gathered and whether the screen out decision was correct;
- For investigations and assessments, information about investigative activities, including reviewers' judgments about the adequacy of those activities;

- For investigations and assessments, information about investigative dispositions, including reviewers' judgments about whether sufficient information was gathered and whether decisions were correct; and

- Information about any actions taken by OKDHS to protect children during and following investigations or assessments, including reviewers' judgments about the adequacy of such actions.

Detailed coding procedures were written to increase inter-rater reliability among the research review team (see Appendix B).

C. The Review Team

1. Case Review Team

Two primary coders, John Goad, A.M. and Adele Prass, A.M., reviewed the referrals, investigations, and assessments included in the sample. The reviewers coded and entered all of the data directly into the database. Both reviewers have extensive CPS experience, having worked as caseworkers and administrators in public child welfare agencies for decades. The principal reviewer, Mr. Goad, is a social worker who has worked in public child welfare for nearly 40 years. During his career he has been directly or administratively responsible for investigations into the alleged abuse or neglect of more than a million children. Ms. Prass has worked in public child welfare for a similar period of time. She has worked as a CPS caseworker, supervisor, and administrator, and was responsible for the provision of child protective services for a county with a population of 5.5 million people. Richard Thompson, Ph.D., Director of Research at the Juvenile Protective Association, analyzed the data and conducted tests for confidence intervals and inter-rater reliability. Dr. Thompson is an investigator on several federally funded grants on outcomes of child maltreatment and mental health services, and has more than 70 peer-reviewed scientific publications.

2. Child Fatality Review Team

Mr. Goad was the principal reviewer for the child fatality review. One other reviewer, Kathy Glenney, A.M., participated in the review. Ms. Glenney has worked in public child welfare as a caseworker, supervisor, and senior administrator for more than 35 years.

See Appendix C for detailed information about the qualifications of study participants for both reviews.

D. Inter-Rater Reliability

Before a complete coding of the screen out, investigation, and assessment samples could be conducted, it was important to establish inter-rater reliability. Inter-rater reliability refers to the

degree to which independent raters agree on the outcome of interest.[46] Kappa scores were used to represent agreement, because these take into account base rates in calculating agreement. Because the raters could endorse any option for each category of response free-marginal Kappa scores were calculated; this approach is a more accurate estimation of agreement than are fixed marginal Kappas, which can be distorted by base rates of responses.[47] Kappa scores above .70 are considered to represent good inter-rater reliability.[48]

This procedure established strong inter-rater reliability between the two reviewers. Details about inter-rater reliability are specified in Appendix A to this report. Because the CPS assessment category included only 17 referrals, the principal reviewer reviewed that entire category. For this reason, there was no need to evaluate inter-rater reliability for the review of CPS assessments.

VIII. CHILD FATALITY REVIEW

A. Overview

As part of my review of the efforts of OKDHS to keep the children in its care safe, I separately evaluated the cases of nine OKDHS wards who the agency found to have died as a result of abuse or neglect since January 1, 2007. Each of these nine children was living in a home about which OKDHS had received at least one prior abuse/neglect referral. Because this review does not focus on a large number of children, the results are not statistically significant, and so the findings cannot be applied to the entire population of children in OKDHS care. Rather, these findings are presented as other examples of OKDHS's failure to take reasonable action to protect the children in its care.

Conclusion: In connection with my review of the files pertaining to the nine children in OKDHS custody who died from child abuse or neglect since January 1, 2007, I conclude that the deaths of five of these children – DS, RP, SW, NW and JT -- could have been prevented if OKDHS had exercised reasonable steps in protecting those children from harm.

The child fatality review was conducted by the principal reviewer, John Goad, A.M., and one additional reviewer, Kathy Glenney, A.M. Ms. Glenney has worked in public child welfare as a case worker, supervisor, and senior administrator for more than 35 years. Her curriculum vitae is attached. The process of the child fatality review was straightforward: the case files supplied by the defendants were reviewed and compared with OKDHS regulations and with basic standards of child welfare practice. The case records totaled 40,000 pages. In addition to being voluminous, the records were in no particular order and, notably, lacked any coherent overarching narrative, this made it extremely difficult for the reviewers, and no doubt for OKDHS managers, to figure out what happened with respect to these children.

After summarizing each of the nine case histories, the OKDHS response is compared with OKDHS regulations and with standards of child welfare practice. This analysis highlights only the instances of poor practice related to the safety of children in OKDHS care and only the most serious breaches among those. Although many issues were noted, this review does not attempt to analyze the cases from the perspective of the permanency or well-being of the children involved.

B. DS

DS was a five-year-old, male child who was in the custody of OKDHS at the time of his murder.